1115 Medication and Related Services Waiver
Response to CMS Questions

Question 1

Describe more fully the coordination of services between physical and mental health care: Where is physical health care treatment provided? Please explain the indigent health care facilities. Why and when will the State refer beneficiaries to the ER? Will it be a problem for new participants to receive a physical exam in their local area?

Response 1

In accordance with State statute, nonprofit hospitals must provide health care services to the community. These required health care services include charity care and government-sponsored indigent health care and may also include other components of community health benefits.

In the Dallas service area, Parkland hospital is a large nonprofit hospital providing indigent care while in the Houston area, BenTaub hospital provides services to indigent populations. Supplementing these hospital-based services are both local health departments and the Texas Department of Health (TDH) that provides services in areas not served by local health departments.

The State of Texas has adopted the "prudent layperson" standard for making referrals to emergency health care. Thus the State will refer any consumer to an Emergency Room when the person has any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent lay person possessing an average knowledge of medicine and health, requires immediate intervention and/or medical attention.

The State recognizes that local communities have a variety of public healthcare providers. Persons with mental illness often need assistance in accessing the public health care system. Under the proposed 1115 waiver individuals will have access to a defined array of BH services that includes Targeted Case Management. The role of the Case Manager is to identify needs and link the individual to appropriate services in the community. Thus, in each locality, the Case Manager would provide assistance to individuals in locating locally available physical health care services and assist the enrollee by linking the individual to those services.

Currently individuals who will be served under the proposed 1115 waiver do not have any means of obtaining physical health care outside of public hospitals and clinics (charity care). Under the waiver these individuals will have access to psychiatrists who perform at least a basic physical examination prior to prescribing medications. If this examination indicates that the person may need a more in-depth examination, a Case Manager will be available to link the consumer to physical health care services in the community.

Question 2

Explain more fully the coordination of care between mental health and substance abuse services for persons with a dual diagnosis. In the State's discussion of substance use and dependency, is alcohol use/abuse included?

Response 2

The single integrated system of behavioral health care in each proposed site offers specialized dual diagnosis services to consumers. Thus, persons served under the waiver will be affiliated with systems of care that provide these services. Having services "at hand" makes linkage to

services less complicated. Persons served through the waiver will also have Case Managers who will link consumers to local service delivery systems inside or outside of the designated health care system. Such services would include, but not be limited to services delivered by providers directly contracting with the Texas Commission on Alcohol and Drug Abuse (TCADA) in the Houston area and NorthSTAR Chemical Dependency providers in the Dallas service area.

Alcohol use would not be treated under the proposed waiver. TCADA and NorthSTAR Chemical Dependency providers focus primarily on alcohol (or other substance) dependence. Alcohol abuse could be addressed by referral and linkage to local support systems.

Question 3

Have persons designing this proposal at Texas MHMR established a relationship with staff at the Social Security Administration (SSA)? Please explain how the State and SSA will coordinate.

Response 3

The State has developed a good working relationship with the SSA in coordinating the entire TWIIA initiative including the Medicaid and workforce components of the initiative. The former head of SSA, Ken Apfel is one of our partners in the CMS Demonstration grant project and will be working with us to assist in strengthening relations with SSA.

We also have a strong working relationship the Texas Association of Centers for Independent Living (TACIL). TACIL is the grantee for SSA's Benefits Planning and Outreach initiative. The initiative will provide better information on benefits choice for persons with disabilities. We would welcome suggestions as to how we could work with SSA to better serve individuals with mental illness. We are particularly interested in confidential exchange of data for evaluative purposes.

We have also been working with the State entity responsible for making disability determinations for SSI (TRC) to develop plans for measuring the effect of the waiver on SSI applications for disability related to mental illness.

The State is open to any recommendations from CMS related to ways in which the State could work more effectively with SSA to serve persons through the 1115 waiver.

Question 4

What substitute or variation of the Texas Implementation of Medicaid Algorithms (TIMA) would the State recommend to local systems of care not using TIMA?

Response 4

The integrated systems of behavioral health care in each locality are already using TIMA. Because TIMA is an evidence-based system that is nationally recognized, the State would not recommend another system. If a locality proposes to deviate from TIMA, the State would have to evaluate the proposal before granting permission for the use of an alternative system.

Question 5

What is the estimated number of waiver participants? We cannot decipher what the numbers represent in tables 5.1 and 5.8, and why they differ. Also, please address the with and without waiver inflation factor.

Response 5

In the initial proposal it was difficult to translate from table 5/1 to table 5.8 without additional detail. In the current submission, the table on page 16 includes the numbers of enrollees. The table is constructed to show savings only for the first year enrollees. This is because it takes a couple of years for the savings to show. If new enrollees were added each year, the initial expenditures would offset savings from earlier periods and individuals who would not have the benefit of five years in the project would mask the extent of the savings from this effort. (Labels for each year were inadvertently left off of the table on page 16). This table is presented in more detail as Appendix 1, and the values on the table are derived from the prior tables in the waiver submission.

Inflation costs are not calculated in the table. While estimates of inflation applied at a detailed level may slightly change the expenditure figures in the table, the result will be no more accurate proportionally than the data presented without inflation factored in. Not applying inflation does mean that the savings represented are in FY 2002 dollars, not variable value dollars over the life of the waiver. Evaluation of the project will reflect actual attrition and the reasons for the attrition, and will include actual costs compared to inflation adjusted without waiver costs.

Question 6

Are any medications excluded? If so, why?

Response 6

The Medications listed in the written response include all medications in the TDMHMR formulary that are indicated for the treatment of Schizophrenia or Bipolar disorder. This list currently includes the new generation anti-psychotic medications and will be expanded to include any medications for the treatment of these disorders that may be released in the future.

Question 7

Has a separate cost been determined as to the provision of targeted case management for everyone in the demo?

Response 7

Yes, page 15 of the waiver request has the table of waiver service costs including the unit and annual costs of case management. Participants need for CM decreases year one through three of participation and remains at about the year three level for years four and five.

Question 8

Why include the outreach cost only in the first year? People may drop out of program and new people may need to be recruited. Will there be continuous outreach regarding this program?

Response 8

The waiver request presents data only for the first year cohort of participants. Subsequent years of operation will bring on smaller cohorts and would include proportional outreach costs.

Question 9

Drug costs will go up, will need to see a trending analysis. How will the State address a national estimate of a 30% increase in pharmacy cost?

Response 9

Inflation for Psychoactive drugs is difficult to project. Whatever inflation there is will be approximately equal for SSI vs. the Waiver. If one is higher than the other, the SSI Medicaid related costs would be higher because traditional Medicaid does not have the cost controls included in the 1115 waiver approach.

Additionally, some of the expensive drugs covered under this waiver now have generic equivalents and others are a matter of one or two years from losing their protected status. The generic equivalents of new-generation medications will provide substantial savings related to drug costs.

In addition, Texas uses TIMA to support physician prescribing decisions and a preferred medication and co-pay procedure to control costs. TIMA helps control costs by insuring that drug and dosage levels are checked frequently under guidelines that reduce over prescribing, by drug and by dosage. Preferred medication policies require that without contraindication, the customer starts drug therapy with the least expensive drugs to effectively meet their needs. In cases where a non-clinically driven decision is made to use a more expensive drug, the co-pay serves to mitigate drug costs.

Question 10

What are the requirements and duties of case managers and physicians? How and who will monitor drug regimens?

Response 10

Physicians will provide medication management for the treatment of the mental health condition. Case managers will provide assistance to individuals to help them gain access to needed medical, social, educational and other services. These activities include:

- Assessment (needs identification),
- Care planning (working with the individual and others to develop goals and to identify a course of action in order to meet the needs of the person served.
- Referral and Linkage to necessary services and supports

- Monitoring and follow up – to ensure that services are meeting the needs of the individual and to identify a change in the needs of persons served.

Question 11

Is an annual assessment on individuals receiving treatment sufficient? Please quantify the statement "at least annually".

Response 11

Formal annual assessments are a minimum requirement. The State recognizes that individuals who are entering the system will have a greater need for services and assessment than individuals who have been receiving treatment for some period of time.

The Case Management function provides on-going informal day-to-day assessment of how the individual is functioning across the life space including an assessment of emerging needs, response to treatment. and monitoring of how well both formal and informal services and supports are meeting the needs of the individual.

The physician will monitor the person for changes in symptomology and response to prescribed Medications. The Case Manager will complement this by monitoring the individual between visits to the physician. The Case Manager will help to inform the physician as to how the individual is responding to treatment with regard to functioning in day-to-day activities.

Question 12

Please clarify whether there is a possible method to obtain information (service satisfaction) from family members or other persons. Privacy not withstanding, persons besides the enrollee could provide good feedback to the State as to the success of the demo.

Response 12

This waiver serves adults who have not yet been determined to be disabled or incompetent. The State values confidentiality and privacy and as such is reticent to poll others regarding the consumer's satisfaction with treatment.

Question 13

Please explain more fully the State-only program. How many persons currently are currently enrolled? What is the eligibility criteria, i.e.. % of FPL? Please explain how the State will address "maintenance of effort" (MOE)? Describe which categories of populations are covered now in your State program versus what you plan to cover in under the waiver.

Response 13

The State will continue to provide the same level of funding to programs in the selected waiver sites as is provided currently. There are two substantial differences between the waiver and the state run program. The state run program operates with limited funding and therefore includes waiting lists. The "waiting list" is not tied to the FPL but rather to the level of severity of illness. The State program identifies a "priority population" but it is only capable of serving a sub-set of that population. The individuals who are the most severely ill rise to the top of the waiting lists while individuals with less severe symptoms (who are the very individuals targeted by this waiver) remain on the waiting lists – often until they have deteriorated to the point of becoming eligible for

SSI and the full Medicaid benefit. Thus individuals who are served under the State program have already deteriorated.

Under the waiver, persons who do not meet the state's priority population definition would receive a package of services sufficient to allow them to maintain and improve functioning. Those who do meet the state's priority population definition and meet requirement for participation in the waiver will be less likely to incur emergency and crisis costs, and thus state funding will be available for the state to provide the most appropriate recovery oriented services.

Question 14

Please provide the 5-year with and without waiver cost. Please provide service and administrative costs for each year of the waiver.

Response 14

Page 16 of the waiver request shows the with and without waiver costs for services. Page 17 lists the administrative costs of $1.5m in IS development and $0.7m for 5 years of administrative support.

Question 15

Without Waiver Service Costs – Why is the State including SSI payments received by Medicaid Eligibles (SSI Check) in the without waiver costs?

Response 15 The SSI payment savings are due to the waiver. Because these are federal expenditures - they have been included in the “without waiver” costs. If the CMS requested table is used, there are no savings due to the waiver in the first five years. This is because the state is not able to accurately collect/represent some Medicaid **cost information in those tables.**

Question 16 How will the State's "Ticket to Work" grant interact with this proposal?

Response 16 The Ticket to work Grant proposal is targeted to a small subset of consumers who are working full-time. In Harris county, the two projects will co-exist, with the Grant project serving a maximum of 300 working consumers. The local health authority will determine eligibility and serve as a focal point for local coordination in both projects. The grant will provide a full health insurance benefit package to the working pre-SSI population. We feel that the richer benefit package offered in the Grant project may incentivize consumers to seek and maintain employment. The grant project will test more costly intervention than the waiver and thus one that is less easily replicated and expanded by states. The waiver project is testing the benefits of an intervention of modest cost to a broader spectrum of adult consumers. This type of intervention is more fiscally feasible for states to implement and expand. If successful, it could provide a model that would be more easily and quickly adopted by states than a full insurance benefits package.